ethylene oxide. Prolonged contact of either fluid with P.V.C. tubing sterilized by ethylene oxide considerably increased the amount of ethylene chlorohydrin formed.

By lengthening progressively the interval between the ethylene oxide sterilization of P.V.C. tubing and the time for conducting such tests it was found that enough gas to give a detectable amount of ethylene chlorohydrin in physiological saline was still emanating up to the sixth day, after which the process could be regarded as having ceased. Under comparable conditions less ethylene chlorohydrin was formed in blood than in saline, the difference probably being due to competitive reactions in blood.

Information on the parenteral toxicity of ethylene chlorohydrin is scanty, and in the absence of reassuring evidence on tolerable levels it would be prudent to suggest that irradiation-sterilized P.V.C. tubing should be discarded after use. Also that plastics sterilized by ethylene oxide should be stored for one week before being used in procedures entailing prolonged contact with body tissues or with fluids containing chloride, as in open heart surgery and renal dialysis. A more detailed account of our investigations will be given elsewhere.—We are, etc.,

A. C. CUNLIFFE.
F. WESLEY.

King's College Hospital Medical School, London S.E.5.

REFERENCE

1 Wesley, F., Rourke, B., and Darbishire, O., *J. Food Sci.*, 1965, **30**, 1037.

Childhood Depression

SIR,—The systematic appraisal of antidepressant drugs in childhood is urgent in the light of the increase in the use of such medication in children's neurotic disorders. Dr. Eva A. Frommer's contribution (25 March, p. 729) is therefore particularly welcome.

It seems important to point out, however, that the results she obtained in a double-blind cross-over trial of phenelzine and chlordiazepoxide (A) versus phenobarbitone and inert placebo (B) do not provide evidence that the first combination is a useful form of treatment in childhood depression. The author is wise to point out that the results only show that the combination in A is superior to that in B.

In the first two weeks of treatment (and two weeks is of course a very short time to assess change in such a chronic form of illness) roughly equal numbers of patients improved on the two regimens (11 out of 15 on A compared to 11 out of 17 on B). After the second two weeks of treatment, when the clinical state was compared with that at the end of the first two weeks, 14 out of 17 patients improved on treatment A, compared with 5 out of 15 on treatment B. These results appear to be just as consistent with the hypothesis that children with neurotic illnesses tend to benefit from being taken off phenobarbitone as with the suggestion that they derive any advantage from phenelzine and chlordiazepoxide.

This is not really very surprising, as many psychiatrists have remarked on the paradoxical effect of the barbiturates in making children irritable—for example, Pond[1] in the case of epileptic and Blachford Rogers[2] in the case of non-epileptic children—and irritability is a prominent feature of childhood depression.—I am, etc.,

The Maudsley Hospital, London S.E.5. PHILIP GRAHAM.

REFERENCES

1 Pond, D. A., *Brit. med. J.*, 1961, **2**, 1377.
2 Blachford Rogers, W. J., in *Modern Perspectives in Child Psychiatry*, ed. J. G. Howells. London.

Management of Chronic Renal Failure

SIR,—I must refer to your report of the symposium on the management of chronic renal failure (22 April, p. 233) held in Londonderry in conjunction with the B.M.A. Annual Clinical Meeting. I am reported as stating that the number of patients referred to our unit in Dublin for long-term dialysis had increased from 16 to 104 "in the same period of time."

There is a considerable amount of confusion here. To begin with it is not clear from the context of the report what is meant by "the same period of time." More important by far is the question of the number of patients referred for long-term dialysis. In my communication there was in fact no mention of referrals for this specific reason, and it is necessary to summarize the facts as stated by me for the purpose of clarification. (*a*) The artificial kidney unit in Jervis Street Hospital opened in June 1958. (*b*) The number of patients referred annually for the treatment of renal failure (acute and chronic) rose from 16 in 1958 to 154 (not 104) in 1966. (*c*) Since November 1964 a limited number of those in the terminal stage of chronic renal failure have been admitted to long-term regular dialysis treatment, and five cadaveric transplants have been carried out in 1966–7. (*d*) There are at present 13 patients on the regular dialysis treatment programme.

It seems that the misinterpretation of my communication in your report may to some extent have arisen from an understandable confusion caused by the very loose and variable terminology in general use concerning haemodialysis in end-stage renal failure. I would suggest that the term "chronic dialysis" be abandoned. It has an ugly implication for the patient, and is calculated to perplex those who are not very familiar with the situation. The European Dialysis and Transplant Association (E.D.T.A.) have adopted the term "regular dialysis treatment" (R.D.T.), which seems much more sensible in every way and clearly applies to the management of a patient who has permanent loss of renal function.

I will conclude by expressing my regret for any inadequacy of presentation on my part which may have led to this misunderstanding.—I am, etc.,

W. F. O'DWYER.

Renal Department and Artificial Kidney Unit, Jervis Street Hospital, Dublin 1.

Platelet Stickiness

SIR,—The plea made by Dr. T. B. Begg for simplifying the mode of expression of platelet stickiness (8 April, p. 109) deserves support.

In a recent article published from this department[1] platelet stickiness was so expressed that the higher the percentage the stickier were the platelets. In our present studies we are continuing to use the method advocated by Begg to avoid "mental gymnastics," and hope that others will follow his suggestion.—We are, etc.,

D. NEGUS.
W. W. SLACK.

Middlesex Hospital, London W.1.

REFERENCE

1 Ham, J. M., and Slack, W. W., *Brit. J. Surg.*, 1967, **54**, 385.

Rheumatoid Arthritis

SIR,—It strikes me that the recurrent part of the histories of patients with rheumatoid arthritis when carefully taken seems to be their assertions, "I have always had sore throats," or "I have always had throat trouble." Linking this with the recent blame placed by researchers on a corynebacterium, perhaps we should in future treat every case of sore throat arising between the ages of 10 and 20 much more seriously, and we should also insist on the addition of aspirin to the antibiotic in such cases.—I am, etc.,

Luton, Beds. K. A. TAYLOR.

Cardiac Catheter Introducer

SIR,—I was interested to read Dr. J. Mackinnon's letter about a cardiac catheter introducer (6 May, p. 377). In this hospital initially I used as a vein dilator a small iris forceps (Allen and Hanbury), but as the inner sides of the blades are serrated I changed it for Arruga's iris forceps made by Down Bros. Like Dr. Mackinnon I found them very helpful and also time saving.—I am, etc.,

P. GHOSH.

Hawkmoor Chest Hospital, Bovey Tracey, Devon.

Attempted Suicide

SIR,—In a recent survey of 680 instances of attempted suicide in Brisbane we estimated that 68% of the attempts could be classed as impulsive. By this we implied that they were not planned or premeditated, but occurred without much thought for consequences in the course of an acute interpersonal and emotional conflict. Our figure of 68% is very much in agreement with findings elsewhere.[1–3]

Of this impulsive group 83% used barbiturate sedatives for their suicidal attempts. We were struck by the very small number of patients using salicylates or compound analgesic preparations, all of which are extremely popular and readily available in Australia.

The reason for this preference for barbiturates is not clear, but it is noteworthy that the majority of the popular analgesics and salicylates are either wrapped as individual powders or supplied as tablets separated from one another between sheets of Cellophane or tinfoil. It is possible, therefore, that this method of packaging acts as a brake on

those making impulsive suicidal attempts. By the time a sufficient dose of the analgesic drug has been extracted from its wrappings some of the emotional heat might have been dissipated, allowing time for wiser counsels to prevail.

It is so very much easier to open a bottle of tablets and swallow the lot in one impulsive gesture than it is to unwrap laboriously each pill carefully embedded in tinfoil. We would like to suggest, therefore, as a contribution to lessening the self-poisoning problem, that the drug firms should be asked to consider whether it would be possible to market all sedative and hypnotic drugs in this individually wrapped fashion. We do not know how such packaging compares in cost with the more conventional methods of supply in cartons and bottles, but it is possible that any additional cost would be more than compensated for by the saving of lives and expensive hospital treatment.—We are, etc.,

F. A. WHITLOCK.
J. E. EDWARDS.

University of Queensland,
Brisbane, Queensland,
Australia.

REFERENCES

1 James, I. P., Derham, S. P., and Scott-Orr., D. N., *Med. J. Aust.*, 1963, 1, 375.
2 Buckle, R. C., Linnane, J., and McConachy, N., ibid., 1965, 1, 754.
3 Kessel, N., *Brit. med. J.*, 1965, 2, 1265 and 1336.

Amphetamine Prescribing

SIR,—If it is accepted, and I believe it is, that there is a small proportion of patients in general practice and in psychiatric practice who need to have amphetamines for very genuine reasons, then surely there could be a case for banning the production, sale, and distribution of amphetamines in any form other than liquid.

The average amphetamine drug could be of such a variety that an eight-ounce bottle is needed for one week's dosage for a medical case. If tablet production is banned by law then it will be very hard for the "drug pusher" to transport eight-ounce bottles, which in fact would be the day dosage—not weekly—for an established amphetamine addict.

The Home Office are at present studying the possibilities of liquid amphetamine only.—I am, etc.,

Peterborough Memorial Hospital,
Peterborough.

D. W. BRACEY.

Early Closure of Myelomeningocele

SIR,—Much has been written about early closure of myelomeningocele, but few have described the actual technique in any detail. It was therefore interesting to read the method described by Mr. G. Brocklehurst and colleagues (18 March, p. 666). May I make a few comments on this problem?

I have found it easier to make the first incision as far away as possible from the neural plaque. Thus the chances of damaging the neural plaque or the roots are minimized. If there is bleeding one need not use the diathermy on the surface of the neural plaque to control it. At the superior edge of the lesion this becomes difficult, as the neural plaque is often closely adherent to the skin edge.

Brocklehurst and colleagues have indicated that they give a dural covering to the neural plaque. This point needs to be debated. Not only is it often impossible to get complete dural covering for the cord but the dissection of the dural flap causes a lot of bleeding, and for this reason is likely to increase the risk of mortality. Occasionally a stitch in the dura may cause a constriction round the neural plaque. If the membranes are left attached to the neural plaque it is impossible to give a covering of the dura as there is too much bulk inside.

Skin closure is made considerably easier by a layer of subcutaneous stitches. There is a ridge of subcutaneous tissue all round the periphery of the lesion, which lies at the junction of the dura, paravertebral fascia, and the thin membranes.[1] This ridge of tissue is strong enough to take the tension necessary to bring the edges of the skin together, and for this reason care should be taken not to damage it during dissection. Stitches can now be put in the skin without any tension.

Three cases out of 25 which occurred over a period of three years had deformities of the feet and wasting of the leg muscles at birth. Muscle wasting was not present in the other children seen soon after birth, although often the muscles were paralysed. The three children with deformed feet showed an interesting anomaly of the spinal cord. In all three cases the exposed neural plaque continued caudally into the closed part of the spinal canal and was adherent to the inner layer of the dura in the sacral canal, tethering the cord down.[1] It is worth while dividing this attachment of the spinal cord to the sacral dura, thus releasing the cord. The caudal end of the spinal cord does not give out any nerve roots for about an inch, and when examined histologically is found to contain only fibrous tissue.[2]

When doing the operation for early closure of myelomeningocele it becomes obvious that the neural plaque which is exposed on the surface is nothing but the spinal cord. Would it not be more accurate to call this condition ectopia myelia or ectopic spinal cord, or perhaps exstrophy of the spinal cord? Myelomeningocele (Myelo-meningo = neural tissue and meninges; cele = sac) seems neither an apt name nor an accurate description.—I am, etc.,

Bombay, India. V. C. TALWALKER.

REFERENCES

1 Talwalker, V. C., *Paediat. Clin. India*, 1967, 2, 50.
2 Dastur, D. K., personal communication.

Gender

SIR,—I refer to your leading article on bacterial endocarditis (13 May, p. 389). Endocarditis lentissiMA, please.—I am, etc.,

Rainham, Essex. E. G. H. KOENIGSFELD.

Future of the Public Health Service

SIR,—Dr. J. J. A. Reid (13 May, p. 432) is to be congratulated on a succinct and timely evaluation of the present Public Health Service and its possible future. It is to be hoped that note will be made in the right quarters of his comments and recommendations. There are many still in public health who have not yet succumbed to the tempting offers of high-salaried posts in the U.S.A. and Canada but whose resolve is seriously weakened by the Government's total lack of urgency in this growing dissatisfaction.

Recruitment into the Public Health Service is unsatisfactory, apart from poor salaries, mainly because there is both clinical and administrative frustration, together with a relative absence of career structure compared with the hospital services. In fact many of the more senior appointments are not even advertised, although representations have been made in this direction.

It would be a sorry day should public health in Britain gradually disintegrate owing to near-sightedness and lack of imagination by the "controllers of our destinies."—I am, etc.,

Sheffield. WILFRID H. PARRY.

SIR,—I am surprised that a man of Dr. J. J. A. Reid's achievements does not realize that different parts of the country need different emphasis in the provision of services (13 May, p. 432). This may be due to his practical public health experience being confined to two adjacent Home Counties, neither noted for environmental or health problems. However, needs vary enormously, and consequently it would seem logical that local health authorities display enormous disparity in size and resources. Whether the standards are indifferent or not must surely be left in the hands of the local inhabitants, to alter if desired through the exercise of local democracy.

Public health doctors are striving for the pay increases already awarded to their colleagues in medicine and local government and should keep this view firmly in mind rather than wander off into the never-never-land of inquiries and committees.

Finally, I am too modest to admit to being dedicated, but would take the strongest possible exception to being described as failing to make the grade in other branches of medicine.—I am, etc.,

Chesterfield. D. P. ADAMS.

Representation of Special Groups on C.C. and S. Committee

SIR,—Members of the special groups of the British Medical Association are indebted to Dr. R. W. Crocket for his comprehensive letter (29 April, p. 315) dealing with the proposed abolition of representatives of special groups on the C.C. and S. Committee.

The figures given by Dr. Crocket in his breakdown of the membership of this committee, the number of consultants represented, and the number of consultants per representative may surprise many consultants, including some who are members of the C.C. and S. Committee.